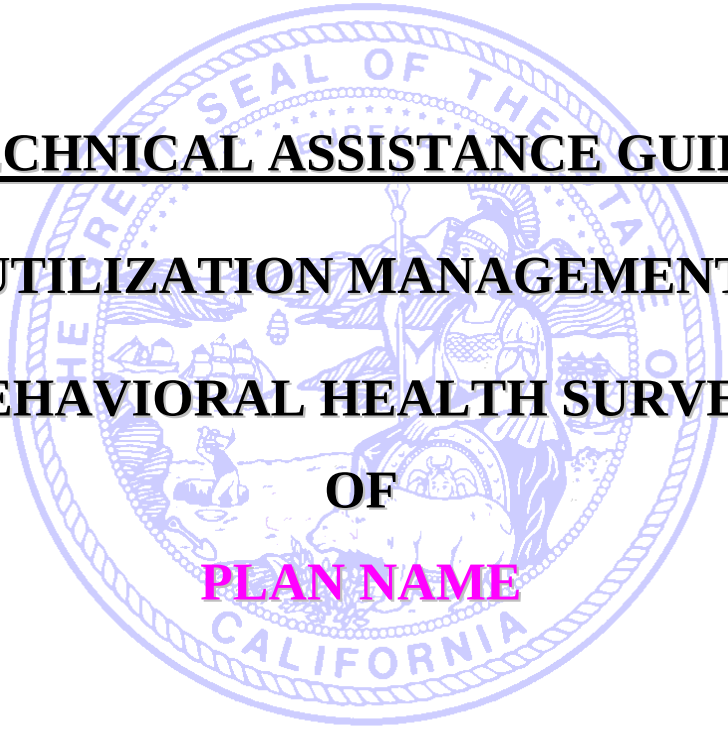
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS



TECHNICAL ASSISTANCE GUIDE

UTILIZATION MANAGEMENT

BEHAVIORAL HEALTH SURVEY

OF

PLAN NAME

PLAN COPY

Issuance of this October 1, 2008 Technical Assistance Guide renders all other versions obsolete.

BEHAVIORAL HEALTH TAG

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UTILIZATION MANAGEMENT REQUIREMENTS*

*The following Utilization Management Requirements from the Full Service TAGs are not applicable to Behavioral Health Plan Surveys:

- Requirement UM-007: Terminal Illness Requirements and Compliance
- Requirement UM-008: UM Delegation Oversight

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Requirement UM-001: UM Program Policies and Procedures

Statutory/Regulatory Citation(s):

CA Health and Safety Code section 1367.01 (b)
A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

CA Health and Safety Code section 1367.01 (c)
A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

CA Health and Safety Code section 1367.01 (i)
A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director and/or senior physician responsible for utilization management
- Utilization Management Director

Document(s) to be Reviewed:

- UM policies and procedures, including org charts and committee descriptions (A UM Program Description may be substituted or in addition to policies and procedures)
- Job Description of the Medical Director responsible for ensuring the UM Process complies with Section 1367.01
- Copy of licenses of the medical director/s
- UM Committee minutes
- Review licensing filing of the Plan's UM program and confirm submission of appropriate policies and procedures.

Key Element 1:

1. The plan has utilization management policies and procedures. CA Health & Safety Code section 1367.01 (b)

Assessment Questions	Yes	No	N/A
1.1 Do policies and procedures describe the process by which the plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of behavioral health care services for plan enrollees?			
1.2 Do policies and procedures include utilization review processes such as prospective review, concurrent review and retrospective review?			

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Key Element 2:

2. A designated medical director is responsible for the oversight of the UM process and holds an unrestricted license to practice medicine in California. CA Health & Safety Code section 1367.01 (c)

Assessment Questions	Yes	No	N/A
2.1 Is a physician designated to provide clinical direction to the UM program and ensure compliance with the requirements of 1367.01?			
2.2 Does the designated individual hold a current unrestricted license to practice medicine in California?			
Is there evidence that the individual is substantially involved in UM Program operations through: 2.3 significant time devoted to UM activities, clinical oversight and guidance to UM staff?			
2.4 active involvement in UM Committee and subcommittees?			

Key Element 3:

3. The Plan ensures telephone access for providers to request authorizations for behavioral health care services. CA Health & Safety Code section 1367.01 (i)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have policies and procedures that describe and ensure telephone access for requesting authorizations for behavioral health care services?			
3.2 Does the Plan maintain telephone access for providers to request authorizations for behavioral health care services?			

End of Requirement UM-001: UM Program Policies and Procedures

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Requirement UM-002: UM Decision Making and Time Frames

Statutory/Regulatory Citation(s):

CA Health and Safety Code section 1367.01 (e) and (g)

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

CA Health and Safety Code section 1367.01 (h) (1-3) and (5)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

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Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- UM Director / Managers
- Medical Director and/or senior physician responsible for UM

Document(s) to be Reviewed:

- UM policies and procedures, including UM decision timeframe requirements
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample UM denial template letters
- Sample of UM denial files to be reviewed on site

Key Element 1:

1. The plan has written policies and procedures for review and approval, modification, delay or denial of services (medical necessity denials) and ensures they are consistently applied. CA Health & Safety Code section 1367.01 (e) and (g)

Assessment Questions	Yes	No	N/A
1.1 Does the plan have policies and procedures to ensure that only licensed physicians (psychiatrists) or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested mental health services on the basis of medical necessity?			
1.2 Do the plan's denial files validate that only licensed physicians (psychiatrists) or a licensed health care professional (competent to evaluate clinical issues related to requested mental health care services) make decisions to deny or modify requested services on the basis of medical necessity? **(Denial Worksheet #10)**			

Key Element 2:

2. The plan has established and implemented written policies and procedures regarding the timeliness of UM Decisions and ensures they are consistently applied. CA Health & Safety Code section 1367.01 (h) (1) and (2)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan make decisions to approve, modify, or deny requests by providers in a timely fashion, not to exceed five business days after the Plan's receipt of the information reasonably necessary to make the determination? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) **(Denial Worksheet #13)**			
2.2 For urgent referrals and requests for other health care services, does the Plan make the decision to approve, modify, or deny requests by providers in a timely fashion, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) **(Denial Worksheet #13)**			
2.3 Does the Plan communicate utilization review decisions to approve, deny, delay, or modify health care services to requesting providers initially by telephone, facsimile or electronic mail and then in writing within 24 hours of making the decision? **(Denial Worksheet #16)**			
2.4 Does the plan communicate UM decisions to approve, deny, delay or modify health care services to enrollees in writing within 2 business days? **(Denial Worksheet #18)**			
2.5 Does the Plan request information from the provider that is reasonably necessary to make a medical necessity decision in a timely fashion (appropriate for the nature of the enrollee's condition)? **(Denial Worksheet #6)**			
2.6 Upon receipt of the requested information, does the plan make decisions to approve, modify or deny the request within the required timeframe? **(Denial Worksheet #13)**			

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Assessment Questions	Yes	No	N/A
2.7 For retrospective reviews, does the Plan make the decision to approve or deny the previous provision of health care services to enrollees, and communicate that decision within 30 days after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? **(Denial Worksheet #13)**			

End of Requirement UM-002: UM Decision Making and Time Frames

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Requirement UM-003: UM Criteria Development

Statutory/Regulatory Citation(s):

CA Health and Safety Code section 1363.5 (a) and (b)
(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b)The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually

CA Health and Safety Code section 1367.01 (b)
These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

CA Health and Safety Code section 1367.01 (f)
The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes.

CA Health and Safety Code section 1374.72
(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:
(1) Outpatient services.
(2) Inpatient hospital services.
(3) Partial hospital services.
(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Co-payments.
(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:
(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.

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(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director or designee
- Senior mental health clinical officer

Document(s) to be Reviewed:

- UM policies and procedures and/or Program document outlining development and approval of UM criteria
- UM review criteria, including the criteria for parity diagnoses (for the diagnosis and treatment of serious mental illnesses, autistic disorders, other pervasive-developmental disorders and serious emotional disturbances of a child).
- Policies and procedures for verifying parity diagnosis including pervasive-developmental disorders and serious emotional disturbances of a child.
- Policies and procedures related to individuals that are seriously mentally ill and do not adhere to Plan policies and procedures and/or treatment plans.
- UM Committee minutes
- Signature page for UM program/plan/policies and procedures

Key Element 1:

1. The plan develops UM criteria consistent with acceptable standards and evaluates them annually. CA Health & Safety Code section 1363.5 (a) and (b); section 1367.01 (b) and (f); and section 1374.72 (d)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan utilize criteria/guidelines when determining the medical necessity of requested health care services?			
1.2 Does the Plan have written UM criteria that are consistent with accepted standards of practice for one or more of the following mental health parity conditions: Schizophrenia Schizoaffective disorder Bipolar disorder (manic depressive illness) Major Depressive disorders Panic disorder Obsessive-compulsive disorder Pervasive developmental disorder or autism Anorexia Nervosa Bulimia Nervosa Severe Emotional Disturbances of Children			
1.3 Are criteria/guidelines developed with involvement from actively practicing mental health care providers?			
Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are: 1.4 Updated annually (or more frequently if needed)?			
1.5 Disseminated to all UM decision-makers?			
1.6 Does the Plan distribute clinical practice guidelines to mental health providers as appropriate?			

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Assessment Questions	Yes	No	N/A
1.7 Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice? (For example, documented approval via minutes from physician discussions; criteria/guidelines have been adopted by reputable physician organizations; criteria/guidelines consistent with national standards from federal agencies.)			

End of Requirement UM-003: Criteria Development

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Requirement UM-004: Communication Requirements for UM Decisions

Statutory/Regulatory Citation(s):

CA Health and Safety Code section 1363.5 (b) (4)
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

CA Health and Safety Code section 1367.01 (d)
If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

CA Health and Safety Code section 1367.01 (h) (1-5)
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or

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modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

CA Health and Safety Code section 1374.30 (i)
No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director and/or senior physician responsible for UM decisions

Document(s) to be Reviewed:

- UM policies and procedures, including UM decision communication requirements
- Sample UM denial template letters, UM approval template letters, and UM extension letters (when the Plan cannot make a decision within the required timeframe)
- Sample denial files to be reviewed on site

Key Element 1:

1. The plan has established and implemented guidelines for UM-related communications to providers and enrollees (including content, form and timeframes). CA Health & Safety Code section 1363.5 (b) (4); section 1367.01 (d); section 1367.01 (h) (3) and (4); and section 1374.30 (i)

Assessment Questions	Yes	No	N/A
1.1 For retrospective UM decisions, does the Plan communicate denials or modifications of health care services to providers in writing? **(Denial Worksheet #17)**			
1.2 Do communications regarding decisions to approve requests by providers specify the specific health care service approved? **(UM Approval Ltr Worksheet #10)**			
1.3 Do the Plan's denial letters provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services? **(Denial Worksheet #20)**			
1.4 Do the Plan's denial letters specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services? **(Denial Worksheet #21)**			
1.5 Do the Plan's denial letters specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services? **(Denial Worksheet #22)**			

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Assessment Questions	Yes	No	N/A
Do written communications to a physician or other mental health care provider of a denial, delay, or modification of a request include the following information: 1.6 The name of the health care professional responsible for the denial, delay, or modification? **(Denial Worksheet #23)**			
1.7 The direct telephone number or an extension of the healthcare professional responsible for the denial, delay or modification to allow the requesting physician or health care provider to easily contact them? **(Denial Worksheet #24)**			
Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: 1.8 File a grievance to the Plan? **(Denial Worksheet #25)**			
1.9 Request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? **(Denial Worksheet #26)**			

Key Element 2:

2. The plan has established and implemented guidelines for communicating to the enrollee and physician if a UM decision will not be made within 5 business days. CA Health & Safety Code section 1367.01 (h) (1) and (5)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan have guidelines for communicating with the enrollee and provider if UM decisions do not meet the required timeframes? **(Denial Worksheet #14)**			
2.2 If the Plan is unable to make a UM decision within the required timeframe, does the plan notify the provider and enrollee of the anticipated decision date?			

End of Requirement UM-004: Communications Requirements for UM Decisions

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Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services

Statutory/Regulatory Citation(s):

CA Health and Safety Code section 1363.5 (a)
(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

CA Health and Safety Code section 1363.5 (b) (4) and (5)
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

CA Health and Safety Code section 1363.5 (c)
(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director or designee
- Member Services staff
- Participating physician

Document(s) to be Reviewed:

- Policies and procedures for disclosure of UM processes and criteria to providers, enrollees, and the public
- Policies and procedures for disclosure to the provider and enrollee of the specific UM criteria used in all decisions based on medical necessity to modify, delay, or deny care
- Template letter(s) with disclosure statement
- Review of disclosure documents including: Provider materials relating to disclosure, disclosures to provider groups and UM vendors, Enrollee materials relating to disclosure, Public materials relating to disclosure
- Review licensing filing of the Plan's UM program to confirm submission of policies and procedures, and the description of the UM Process.

Key Element 1:

1. The plan shall disclose to network providers, contractors and enrollees the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan. CA Health & Safety Code section 1363.5 (a)

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Assessment Questions	Yes	No	N/A
1.1 Do Plan policies and procedures provide for the disclosure of the process the Plan uses to authorize, modify or deny health care services?			
1.2 Does the Plan disclose the UM process information to network providers?			
1.3 Does the Plan demonstrate that it discloses UM processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request?			
1.4 Does the Plan demonstrate that it discloses to the enrollee and provider the UM criteria used as a basis to modify, deny or delay services in specified cases under review?			
1.5 Are UM Criteria available to the public upon request, which may include the availability through electronic communication means?			
1.6 Is disclosure of UM criteria to the public accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."?			

End of Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services

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Requirement UM-006: UM Processes as Part of the QA Program

Statutory/Regulatory Citation(s):

28 CCR 1300.70 (a) (1)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

28 CCR 1300.70 (b) (2) (G) (5)
Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

CA Health and Safety Code sections 1367.01 (e), (h) and (j)
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the

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criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.
(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- UM Director
- QM Director
- Medical Director

Document(s) to be Reviewed:

- Policies and procedures for UM
- UM or QM Annual Work Plan
- UM or QM Committee minutes
- Trending reports
- Activity summaries
- Audit Reports
- Enrollee & Provider Satisfaction Surveys (UM-related questions and results)
- Corrective action plans

Key Element 1:

1. The Plan has established and implemented a QA process to assess and evaluate their compliance with UM requirements. CA Health & Safety Code sections 1367.01 (e), (h) and (j)

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Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a process in place to routinely and systematically evaluate complaints and assess trends to identify potential quality issues in the UM process and regularly report this information to appropriate bodies?			
1.2 Does the Plan have a process in place to monitor and assess compliance with timeliness of decision-making, timeliness of notification, and turnaround times for UM functions?			
1.3 Has the Plan established and implemented policies and procedures to monitor and assess compliance with the use of appropriate licensed providers in making denial decisions and the appropriate use and application of criteria in making medical necessity decisions?			
1.4 Has the Plan established and implemented policies and procedures to audit denial letters ensuring the required information is included, and communicated to the appropriate user, providers and/or enrollees?			
1.5 Does the Plan systematically and routinely analyze its evaluation of the UM process to identify any potential quality issues in the UM process?			
1.6 Does the Plan develop, communicate and implement corrective action plans when potential quality issues are identified in the UM process?			
1.7 Does the Plan evaluate the effectiveness of any corrective action plan (using performance measures, for example) and make further recommendations to improve the UM process?			
1.8 Does the Plan systemically and routinely analyze UM data to monitor for potential over and under utilization?			

Key Element 2:

2. The scope of quality assurance monitoring includes assessment and evaluation of provider referral and specialist care patterns of practice. **28 CCR 1300.70 (a) (1); 28 CCR 1300.70 (b) (2) (G) (5)**

Assessment Questions	Yes	No	N/A
2.1 Does the plan's quality assurance/utilization review mechanism encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists based on reasonable standards established by the plan and/or delegated providers?			
2.2 Does the Plan have a process in place to routinely monitor and assess access to specialist care?			
2.3 Does the Plan analyze its evaluation of access to specialist care?			
2.4 Does the Plan have a process to routinely monitor and assess access to specialist care for any delegated providers?			
2.5 Does the Plan identify, communicate and implement corrective actions when potential access issues are identified in the UM process?			
2.6 Does the Plan evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues?			

End of Requirement UM-006: UM Processes as Part of the QA Program

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Requirement UM-007: Terminal Illness Requirements and Compliance

This requirement does not apply to Behavioral Health plans.

End of Requirement UM-007: Terminal Illness Requirements and Compliance

Requirement UM-008: UM Delegation Oversight

This requirement does not apply to Behavioral Health plans.

End of Requirement UM-008: UM Delegation Oversight

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Requirement UM-009: Mental Health Parity Coverage & Claims Administration

Statutory/Regulatory Citation(s):

CA Health and Safety Code 1374.72 (a), (c) and (e)

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.
(2) Copayments.
(3) Individual and family deductibles.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Mental health claims director/manager
- Senior mental health clinician responsible for mental health

Document(s) to be Reviewed:

- Policies and procedures, protocols documents relating any application of limits compared to medical or surgical services
- Member materials regarding benefit limits
- Customer Service staff materials used to quote member benefits
- Sample of claim denial files to be reviewed on site

Key Element 1:

1. Limits on annual/lifetime maximum benefits, co-payments, individual and family deductibles for mental health services are consistent with, or no more stringent than, any limits placed on medical or surgical services. CA Health & Safety Code section 1374.72 (a), (c) and (e)

Assessment Questions	Yes	No	N/A
1.1 Are coverage limits, co-payments and co-insurance for mental health services consistent with or no more stringent than limits for medical/surgical services?			
When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions? 1.2 Maximum lifetime benefits? **(Mental Health Parity Claims Review Worksheet #11)**			
1.3 Individual and family deductibles? **(Mental Health Parity Claims Review Worksheet #9, 10)**			
1.4 Co-payments? **(Mental Health Parity Claims Review Worksheet #6)**			
1.5 Co-insurance? **(Mental Health Parity Claims Review Worksheet #7)**			
1.6 Benefit limit? **(Mental Health Parity Claims Review Worksheet #8)**			

End of Requirement UM-009: Mental Health Parity & Claims Administration

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Requirement UM-010: Mental Health Triage and Referral

Statutory/Regulatory Citation(s):

28 CCR 1300.74.72 (d) and (f)
(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that an enrollee has one or more conditions set forth in Health and Safety Code section 1374.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether or not the final diagnosis confirms the preliminary or initial diagnosis.

(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72.

CA Health and Safety Code section 1363.5 (b)
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually

CA Health and Safety Code section 1367.01 (e) and (j)
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Senior mental health clinician responsible for triage and referral
- Mental Health Medical Director
- Triage Center Manager and personnel

Document(s) to be Reviewed:

- Triage Policies and Procedures
- Utilization Management Committee and/or work group meeting minutes
- Record of periodic review and Plan assessment to ensure timely access and ready referral in accordance with 1300.74.72(f).
- Job descriptions of call center clinical and non-clinical personnel
- Review of cases from the Triage Center's telephone log, including cases in which the enrollee required emergent care or urgent care.

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Key Element 1:

1. The Plan maintains a telephone intake system for enrollees, which is staffed by trained personnel who are either individually licensed mental health professionals, or supervised by a licensed mental health professional, and which provides for appropriate crisis intervention and initial referrals to mental health providers. 28 CCR 1300.74.72 (f); California Health & Safety Code section 1367.01 (i)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an enrollee telephone intake system that is staffed by trained personnel who are individually licensed or are supervised by a licensed mental health professional?			
1.2 Does the Plan have policies and procedures and/or training that define protocols for initial referrals to mental health providers?			

Key Element 2:

2. If the Plan requires that an enrollee access the mental health delivery system through a centralized triage and referral system, the Plan's protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the enrollee's mental status and level of functioning. 28 CCR 1300.74.72 (f)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan require that enrollees access the mental health delivery system through a centralized triage and referral system?			
2.2 Do the Plan's protocols for mental health triage and referral address the level of urgency relative to the enrollee's mental status and level of functioning?			
2.3 Do the Plan's protocols for mental health triage and referral address the appropriate level of care relative to the enrollee's mental status and level of functioning?			

Key Element 3:

3. The Plan has established standards and goals for the timeliness of response to its triage and referral telephone lines and measures performance against those standards. 28 CCR 1300.74.72 (f); California Health & Safety Code section 1367.01 (j)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have established standards and goals for timeliness of response to triage and referral telephone lines?			
3.2 Does the Plan measure performance against standards at least quarterly?			
3.3 If the Plan does not meet its goals, does it take corrective action?			
3.4 Does the Plan re-measure results after corrective action has been implemented?			

Key Element 4:

4. The Plan reviews and updates protocols on parity conditions, when appropriate, on a regular basis. CA Health & Safety Code section 1363.5 (b)

Assessment Question	Yes	No	N/A
4.1 Does the Plan review and update triage protocols on parity conditions on a regular basis?			

Key Element 5:

5. Licensed clinical staff members make decisions about the type and level of care to which enrollees are referred. CA Health & Safety Code section 1367.01 (e)

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Assessment Question	Yes	No	N/A
5.1 Do Licensed clinical staff make decisions about the type and level of care to which enrollees are referred?			

End of Requirement UM-010: Mental Health Triage and Referral

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Requirement UM-011: Standing Referrals

Statutory/Regulatory Citations:

CA Health and Safety Code section 1367.01 (h) (4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

CA Health and Safety Code section 1374.16 (a-f)

(a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the

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enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

Individual(s)/Position(s) to be Interviewed:

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Provider Relations
- UM Director

Documents to be Reviewed:

- Policies and procedures for standing referrals of enrollees
- Plan reports on monitoring of standing referrals
- Plan reports on monitoring of standing referrals at UM delegated entities
- Policies and Procedures regarding identifying appropriate specialists and specialty care centers for standing referrals
- Sample of Standing Referral files to be reviewed on site
- Corrective Action Plans

Key Element 1:

1. The Plan has established policies and procedures for standing referrals of: (a) enrollees who need continuing care from a specialist, and (b) enrollees who require specialized care over a prolonged period of time for the purpose of having the specialist coordinate the enrollee's health care. CA Health & Safety Code section 1374.16 (a-f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established policies and procedures for standing referrals?			
1.2 Does the Plan disseminate those policies to primary care providers (e.g., via provider manual)?			

Key Element 2:

2. The Plan makes determinations within three (3) business days of the date a request for standing referral is made and all appropriate information necessary to make the determination is provided. When approved, the Plan makes the referral within four (4) business days of the date the proposed treatment plan, if any, is submitted to the Plan medical director or his/her designee. CA Health & Safety Code section 1367.01 (h) (4) and section 1374.16 (c)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan make a determination regarding requests for standing referrals within three (3) business days? **(Standing Referrals Worksheet #9)**			
2.2 Once approved, does the Plan make the referral in 4 (four) business days of the proposed treatment plan? **(Standing Referrals Worksheet #11)**			
2.3 Do communications to approve standard referrals specify the specific services approved? **(Standing Referrals Worksheet #14)**			
2.4 Do denial letters provide a clear and concise explanation of the reasons for the denial? **(Standing Referrals Worksheet #17)**			
2.5 Do the Plan's denial letters specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services? **(Standing Referrals Worksheet #18)**			

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Assessment Questions	Yes	No	N/A
Do written communications to a physician or other health care provider of a denial, delay, or modification of a request include the following information: 2.6 The name of the health care professional responsible for the denial, delay, or modification? **(Standing Referrals Worksheet #19)**			
2.7 The direct telephone number or an extension of the healthcare professional responsible for the denial, delay or modification to allow the requesting physician or health care provider to easily contact them? **(Standing Referrals Worksheet #20)**			
Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: 2.8 File a grievance with the Plan? **(Standing Referrals Worksheet #21)**			
2.9 Request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? **(Standing Referrals Worksheet #22)**			

Key Element 3:

3. The Plan appropriately approves the treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time. CA Health & Safety Code section 1374.16 (a), (b) and (e)

Assessment Question	Yes	No	N/A
3.1 Does the Plan approve a treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time? **(Standing Referrals Worksheet #10)**			
3.2 Does the Plan have a process for validating specialists and specialty care centers are accredited or designated as having special expertise? **(Standing Referrals Worksheet #15)**			

Key Element 4:

4. When a specialist or specialty care center has been approved to coordinate the enrollee's health care, the Plan approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care physician's services, subject to the terms of the treatment plan. CA Health & Safety Code section 1374.16 (b)

Assessment Question	Yes	No	N/A
4.1 Does the Plan demonstrate that it complies with section 1374.16(b) and approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care physician's services, subject to the terms of the treatment plan? **(Standing Referrals Worksheet #16)**			

End of Requirement UM-011: Standing Referrals